

Shared and Specific Susceptibility Loci for Schizophrenia and Bipolar Disorder

A Dense Genome Scan in Eastern Quebec Families

Maziade et al., Molecular Psychiatry (2005)

P8139 Statistical Genetic Modeling

Section 1

Part I: Background & Study Design

Study Objective

Primary Goal: Identify susceptibility loci for schizophrenia (SZ) and bipolar disorder (BP)

Key Questions:

- Are there genetic loci **shared** by both SZ and BP?
- Are there loci **specific** to each disorder?

Why study both disorders together?

- Family studies show SZ and BP tend to co-aggregate in families
- Previous genome scans studied them separately
- Studying both concurrently avoids diagnostic bias

Background: The Diseases

Bipolar I Disorder (BP):

- Mood disorder with manic and depressive episodes
- Life time prevalence of 0.6%; Bipolar spectrum disorders: 1-2%
- Highly heritable (60-85%)
- ~70% reported psychotic symptoms

Schizophrenia (SZ):

- Key features include hallucinations, delusions, disorganized speech, abnormal motor behavior, diminished emotional expression
- Lifetime prevalence in population is 0.3-0.7%
- High heritability (70-80%)
- **Schizoaffective Disorder:**
 - Schizophrenia with mood symptoms (mania and/or depression)
 - lifetime prevalence is ~0.3%

Complex Genetic Disorders

- Non-Mendelian inheritance - class: what if it is Mendelian inheritance
 - monozygotic twin concordance rate is 40-50%
- Genetic heterogeneity
 - different loci / different mutation
- Polygenic
 - multiple genes likely involved within individuals
- Incomplete penetrance
 - gene-environment interaction
- Phenocopies
 - similar clinical phenotype induced by environmental factors
 - eg., prenatal or perinatal adversities including stress, infection, or other medical complications
- Other risk factors: neurodevelopmental factors, substance exposure, psychosocial stressors, etc.

Study Population: Eastern Quebec Families

Sample Characteristics:

- 21 multigenerational families from Eastern Quebec, Canada
- Average of 6 affected individuals (SZ or BP) per family
- N = 480 family members (DNA available)
- 47 deceased affected ancestors included in pedigree analysis

Family Selection Criteria: - class: why the criteria

- At least one first-degree relative with same disorder as proband
- At least two additional affected relatives (first/second/third-degree)
- At least four affected members per family

Family Composition:

- 7 SZ pedigrees (85%+ affected by SZ spectrum among ill members)
- 6 BP pedigrees (85%+ affected by BP spectrum among ill members)
- 8 mixed pedigrees (both SZ and BP)

Section 2

Part II: Methods Overview

Methods: The Big Picture

Overall Analytical Strategy:

Step 1: Define phenotypes (who is "affected"?)

|

v

Step 2: Genotype families using microsatellite markers

|

v

Step 3: Perform model-based linkage analysis

|

v

Step 4: Calculate LOD scores across genome

|

v

Step 5: Apply significance thresholds (multiple testing)

|

v

Step 6: Identify candidate susceptibility regions

Background Concept: What is Linkage?

Linkage = The tendency for genes/markers close together on a chromosome to be inherited together

- Linkage analysis requires pedigree data because it detects co-segregation of chromosomal regions through meioses

Key Principle (from Lecture 4):

- If a marker is **physically close** to a disease gene, they will **co-segregate** within families
- The closer they are, the less likely recombination occurs between them

Recombination Fraction (θ):

- θ = probability of recombination between two loci
- $\theta = 0.5$: loci are unlinked (different chromosomes or far apart)
- $\theta < 0.5$: loci are linked
- $\theta = 0$: loci are completely linked (no recombination)

Background Concept: Microsatellite Markers

What are microsatellites?

- Short tandem repeats (STRs) of 2-4 nucleotides (e.g., CA-CA-CA-CA, or CA-CA, etc.)
- Highly polymorphic: many different alleles in population
- Scattered throughout the genome

Why use microsatellites for linkage analysis? (class: how is it better than snp)

- High heterozygosity → more **informative meioses**
- A pedigree contributes to LOD score only if key individuals are heterozygous
- More alleles = better ability to track inheritance

This study used:

- 607 microsatellite markers
- 350 markers at 10 cM resolution (initial scan) - *a marker for every 10 cM

Methods Step 1: Phenotype Definitions

Three diagnostic classes analyzed:

Phenotype	Narrow Definition	Broad Definition
SZ	SZ only (N=71)	SZ + schizophreniform + schizotypal (N=81)
BP	BP I only (N=48)	BP I + BP II + recurrent depression (N=72)
CL	SZ + BP I + schizoaffective (N=134)	CL narrow + depression + schizotypal (N=169)

CL = “Common Locus” phenotype

- Tests hypothesis that some loci are shared by both disorders
- Combines SZ and BP phenotypes

Diagnostic blindness: ensures that clinical diagnosis is assigned independently of family structure

Methods Step 2: Transmission Models

Model-based linkage analysis requires specifying:

- 1 **Mode of inheritance:** Dominant vs. Recessive
- 2 **Disease allele frequency:** How common is the risk allele?
- 3 **Penetrance:** $P(\text{affected} \mid \text{genotype})$

Two models used in this study: - why these number - 0.07%prevalence; ask class?

Parameter	Dominant Model	Recessive Model
Disease allele frequency	0.01	0.10
Penetrance (high age)	0.70	0.70
Phenocopy rate	0.20	0.10

Why test multiple models?

- True inheritance pattern unknown for complex diseases
- Maximizing over models increases power but also Type I error

Background Concept: LOD Score

LOD (Log of Odds) Score measures evidence for linkage:

$$LOD(\theta) = \log_{10} \frac{L(\theta)}{L(\theta = 0.5)} = \log_{10} \frac{\text{Likelihood under linkage}}{\text{Likelihood under no linkage}}$$

Interpretation:

- LOD = 0: No evidence either way
- LOD = 1: Data 10x more likely under linkage
- LOD = 2: Data 100x more likely under linkage
- **LOD = 3: Traditional threshold for “significant” linkage**

LOD scores are additive across families:

$$LOD_{total} = \sum_{i=1}^n LOD_i$$

Methods Step 3: Linkage Analysis Details

Two-point vs. Multipoint Analysis:

- **Two-point:** Tests linkage between disease and ONE marker
- **Three-point (multipoint):** Uses flanking markers together
 - More informative, extracts more information
 - Each marker included in two three-point analyses

Mod Score Approach:

- Maximize LOD score over θ AND over model parameters
-

$$\text{Mod Score} = \max_{\theta, \text{models}} \text{LOD}(\theta)$$

- Tests 8 combinations: 2 phenotype levels (narrow vs broad) \times 2 transmission models (dominant vs recessive) \times 2 analysis types (affect/unaffected vs affected-only)

Software: FASTLINK (version of LINKAGE) - what it is

Methods Step 4: Multiple Testing Correction

The Problem:

- 607 markers \times 3 phenotypes \times 8 model combinations = many tests!
- High risk of false positives

Solution: Lander & Kruglyak (1995) Thresholds

Category	Z-score	Interpretation
Significant	≥ 4.0	Genomewide significant ($p < 0.05$)
Suggestive	≥ 2.6	Expected once per genome scan by chance
Confirmatory	≥ 1.9	Only in regions with prior evidence

Additional correction in this study:

- Raised thresholds by 0.70 (following Hodge et al.)
- Because: 24 non-independent analyses per marker

Methods Step 5: Heterogeneity Analysis

What is genetic heterogeneity?

- Same phenotype caused by different genes in different families
- Common in complex diseases

Problem: If only some families are linked to a locus, the overall LOD score may be diluted

Solution: Admixture Model (HOMOG program)

- Estimates proportion of families linked (α)
- Calculates HLOD (heterogeneity LOD)
- Applied to signals with mod score > 1.9

$$HLOD = \log_{10} [\alpha \cdot L(\theta) + (1 - \alpha) \cdot L(\theta = 0.5)] - \log_{10} L(\theta = 0.5)$$

Section 3

Part III: Results

Genetic Nomenclature: Loci and Markers

- **1. Chromosomal Location (e.g., 2q12.3)**

- **2:** The chromosome number.
- **q:** The “long arm” of the chromosome (p stands for the “short arm”).
- **12.3:** The specific band and sub-band on that arm. Numbers increase as you move further from the centromere (the center).

- **2. Genetic Markers (e.g., D15S122)**

- **D:** DNA.
- **15:** Located on Chromosome 15.
- **S:** A “single-copy” sequence (a unique landmark in the genome).
- **122:** The registration number for that specific marker.

- **The Relationship:**

- Think of **2q12.3** as a **neighborhood** (a general region).
- Think of **D15S122** as a **specific street address** (a precise landmark) used by researchers to verify if a disease gene is nearby.

Results summarized in Table 1

- **Significant Linkage Findings (MOD Score > 4.0):**
 - **BP:** 15q11.1 (D15S122), 18q12.3 (D18S1145), 16p12.3 (D16S410)
 - **CL:** 15q26 (D15S1014), 18q21.1 (D18S472)
- **Suggestive Linkage Findings (MOD Score > 2.6):**
 - **BP:** 12q23.1 (D12S1030), 3q21.2 (D3S3023), 10p13 (D10S674)
 - **SZ:** 6p22.3 (D6S334), 18q21.1 (D18S851), 13q13.3 (D13S1491)
 - **CL:** 16p13.1 (D16S3041), 2q22.1 (D2S298), 13q14.1 (D13S1247)
- **Novelty and Replication (see Table 3):**
 - **Novel Discovery:** The linkage signal at **15q26** for the shared phenotype appeared to be a novel finding.
 - **Confirmatory Evidence:** The finding at **6p22.3** for SZ (MOD score ≥ 1.9) aligns with previously reported genome-wide significant findings, reinforcing its importance.
- Findings were not driven by just one or two families. Instead, the genetic signal is distributed across multiple pedigrees (see Table 2)

Figure 1: Visualizing Linkage across Chromosomes

- **X-axis:** Represents the physical distance along the chromosome (measured in cM).
- **Y-axis:** Represents the MOD Score (the strength of the evidence).
- **Example:** Chromosome 18 shows overlapping linkage peaks for SZ, BP and the combined phenotype, suggesting a shared psychosis susceptibility locus rather than diagnosis-specific genes.

Section 4

Part IV: Discussion Questions

Evidence for Shared Loci Between SZ and BP

- Data indicates overlapping susceptibility regions, suggesting that SZ and BP may share a common biological etiology in specific areas.
- **Key Shared Hotspots:**
 - **Chromosome 18 (18q12-q21):** This region showed consistent significant or suggestive linkage across SZ, BP, and combined phenotypes.
 - **Chromosome 15 (15q26):** Evidence suggests the presence of one or more susceptibility genes contributing to either or both disorders.
- These results strongly support the hypothesis that some genetic risk factors are **not specific to one diagnosis** but are shared across the spectrum of these two major psychoses

Limitations

1. Statistical Thresholds

- Unclear if these criteria fit a small number of large families.
- The effect of a two-step scan (sparse then dense) is hard to simulate.

2. Sensitivity of Heterogeneity

- Current tests may fail to detect between-family heterogeneity (different families having different genetic causes).

3. Complexity of Replication

- Difficult to define “true replication” across different studies due to variations in:
 - Sampling & Diagnostics
 - Statistical methods & Genetic markers

Implications & Future Direction

- **Proposed Genetic Architecture Models**

- **Combination Model:** Disease specificity (SZ vs. BP) arises from unique combinations of multiple shared genes.
- **Modifier Gene Model:** SZ and BP share core genes; specific modifier genes determine the final clinical phenotype.

- **Evidence for Complex Inheritance**

- **Necessary but Not Sufficient:** Genes at loci like **6p22 (SZ)** or **16p12 (BP)** require interactions with other genes to trigger the disorder.
- **Affected-Only (AO) Evidence:** Significant signals in AO analysis suggest incomplete penetrance (healthy members also carrying the gene).
- The presence of multiple signals in one sample allows for the study of gene-gene interactions (epistases).

- **Future Direction**

- Expand statistical power using a second sample of 500 members, ultimately identifying defective genes and paving the way for new treatments.

Questions for Class Discussion

Conceptual Questions:

- 1 Why did the authors use **model-based** (parametric) linkage analysis instead of model-free methods for this study? What are the trade-offs?
- 2 The study found that some chromosomal regions showed linkage signals for the **combined phenotype (CL)** but not for SZ or BP alone. What does this suggest about the genetic architecture of these disorders?

Methodological Questions:

- 3 How does the **multiple testing problem** manifest in this study? Do you think the Lander & Kruglyak thresholds adequately address all sources of multiple testing?
- 4 The authors used both **narrow and broad** phenotype definitions. How might phenotype misclassification affect LOD scores and power?

Questions for Class Discussion (cont.)

Connecting to Course Material:

- 5 In Lecture 4, we learned that LOD scores require specifying **penetrance** values. This study used age-dependent penetrance. Why is this important for late-onset disorders?
- 6 The maximum family LOD score was only ~ 2.0 (Table 2), yet the combined scores reached significance. What does this tell us about **genetic heterogeneity** and the **oligogenic** nature of these disorders?

Critical Thinking:

- 7 This is a **two-stage design** (initial sparse scan + dense follow-up). What are the advantages of this approach compared to performing dense genotyping from the start?